[RO/22/0]

PRINTED: 09/17/2007 FORM APPROVED

	-	I AND HUMAN SERVICES & MEDICAID SERVICES		المرام المال المال		APPROVED . 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD B. WING		(X3) DATE S COMPL	ETED
		09G12 1	25, 144,462			31/2007
name of P	ROVIDER OR SUPPLIER		ş	TREET ADDRESS, CITY, STATE, ZIP 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	CODE	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE RE-APPROPRIATE	(X5) COMPLETION DATE
W 000			W 00		, ,	
	August 29, 2007 th survey was initiated process. A randon	rvey was conducted from rough August 31, 2007. The dusing the fundamental survey a sample of four clients were pulation of eight females with disabilities.				
W 120	observations at the program, interviews day program, review records to include the reports.	survey were based on group home, one day sat both the group home and wor clinical and administrative the facility's unusual incident	\A/ 40	w120)	· .	
	OUTSIDE SOURC	ES ssure that outside services		This Standard with as evidenced by:	ll be met	
	Based on observati record review, the i monitor each client	is not met as evidenced by: ions, staff interview, and facility failed to effectively 's day program to assure that t for one of four clients in the)				
,	August 29, 2007 at revealed an emerg 18, 2007. The ER ingestion of a styro Qualified Mental Re August 30, 2007 at revealed that the day	at #3's medical record on approximately 11:00 AM ency room report dated April report indicated a diagnosis of foam cup. Interview with the etardation Professional on approximately 11:00 AM ay program staff was feeding		program staff, pro additional training needed on mealth and use of adaptive	ovide ngsas me protocol	9-13:07 onogaina
BORATORY	the client using a st	yronosm cup. DERSUPPLIER REPRESENTATIVES SIGN	NATI IDE	egupment.	_ . J	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Nancy Branch

Director Residential Services

ib[i|o7

PRINTED: 09/17/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (K1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED a. Building B. WING 09G12¶ QB/31/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE 1 D I WASHINGTON, DC 20019 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL . PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY WIZO, continued ... W 120 Continued From page 1 W 120 · omer will conduct follow-up Review of Client #3's feeding protocol dated visits at the day program site, address concerns.
and issues as they arise. October 20, 2006 revealed that the client should be fed with an adaptive cup (spout cup). Further interview with the QMRP indicated that the proper adaptive equipment was available at the day program. However the day program staff falled to use the proper equipment as ordered. W 130 483.420(a)(7) PROTECTION OF CLIENTS W 130 RIGHTS W130 The facility must ensure the rights of alliclients. This Standard will be met Therefore, the feicility must ensure privatcy during as evidenced by: treatment and care of personal needs. . . · RN will address UPN who This STANDARD is not met as evidenced by: 9-20-07 failed to implement privacy standards. Based on observation, the facility failed to ongoing implement an effective system to protect the clients' right for privacy during morning medication administrations for three of the four - LPN'S will receive additional clients residing in the facility. (Clients #1, #2, #6 training on adherence to and #7) privacy during medication The finding includes: passes. The morning medication administration · RN will conduct random observations on August 29, 2007 beginning at medication pass monitoring to further ensure 7:20 AM. The Licensed Practical Nurse (LPN) was observed administering medications to Clients #1, #2, #6 and #7 at the dining room table. The nurse interrupted the clients breakfast to compliance with this . administer their medications. At the time, direct care staff were assisting clients with eating their standard. breakfast. 483.420(a)(12) PROTECTION OF CLIENTS W 137 W 137

The facility must ensure the rights of all clients.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OSCILLA B. WING OSCILLA CONTROLLAR CONTROLLA	/2007
NAME OF PROVIDER OR SUPPLIER I D 1 STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 28819 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(XE)
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BIE CORRECTIVE BIE BIE CORRECTIVE BIE BIE BIE BIE BIE BIE BIE BIE BIE BI	DATE
W 137 Continued From page 2 Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each clients clothing and personal belongings were maintained for eight off eight clients (Clientsi#1,#2,#3, #4, # 5) #6, #7 and #8) residing in the facility. The findings include: 1. During the environmental inspection conducted on August 31, 2007, the surveyor observed that all of the clients undergarments W 137 W 137 W 137 Thus Standard will be met as evidenced by: evidenced by; Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by: Thus Standard will be met as evidenced by: Evidenced by:	2.5.07 orgovig

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	-	09G121	1	B. WING		
NAME OF F	, , , , , , , , , , , , , , , , , , ,	053123	<u>-</u> -	1		1/2007
I D I	rovider or supplier			STREET ADDRESS, CITY, STATE, ZIP C 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFL TAG		n should be	(X5) COMPLETION DATE
W 148	483.420(c)(6) COM CLIENTS, PARIENT	MUNICATION WITH IS &	W 1	W137 Continue	d	
	parents or guardian changes in the clied	tify promptly the client's of any significant incidents, or it's condition including, but not tress, accident, death, abuse, sence.		(3) Home Manager vepair and/or picture frame.	will replaces	9.5.07 ongoing
	Based on interview failed to document or guardians of sign client's condition, for sample. (Client #3)	•	-	Home Manager wi routine environments document findings address items requ	il publits, and urung	
W 153	entrance conference Mental Retardation indicated the Cleint Review of the client 29, 2007 at approximate emergency room retained a styrofoam cup, revealed that the faincitied of this includindicated that notific members should be reports.	r at 7:50 PM, during the evia telephone, the Qualified Professional (QMRP) #3 had family involvement. Is medical record on August mately 11:00 AM revealed an port dated April 18, 2007. ated a diagnosis of Ingestion Review of the incident mily members were not ent. The QMRP further ration of guardians/family document on incident	W 1	rvill be filed for WI48 This Standard wir as evidenced by: amer will ensure the members are notificated ance to the in	ntation review. Il be met of family	[·
	mistreatment, negle injuries of unknown	sure that all allegations of ct or abuse, as welltas source, are reported administrator or to other				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/17/2007

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING B, WING. 09G121 08/31/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE 101 Washington, DC 20019 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETION DAYS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) W 153 Continued From page 4 W 153 W153, Continued ... officials in accordance with State law through established procedures. This Standard will be met as This STANDARD is not met as evidenced by: evidenced by: Based on interview, review of unusual incidents. Day Program STAFF reportedly made all notifications. and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to - omer will confer with district law (22 DCMR, Chapter 35, Section day program whenever of incidents occur to ensure of conspletion of notifications, 3519.10) for one of the four clients included in the sample. (Client #3) The finding includes: @ Qmep will maintain documentation Review of the Client #3's medical record on August 29, 2007 at approximately 11:00 AM very to support revealed an emergency room report dailed April notification to administrator 19, 2007. The ER report indicated a diagnosis of and other officials. ingestion of a styrofoam cup. There was no evidence that this incident has been regorted to other officials (Departement of Health) as required W 156 483.420(d)(4) STAFF TREATMENT OF WIS6 W 156 CLIENTS This Standard will be met as evidenced by: The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator and State officials within five working days of the incident, for two of the four clients in the sample: (Clients #1 and #3)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/17/2007

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES QMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 09G121 08/31/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE 101 WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX COMPLETION TAG DEFICIENCY) W 156 Continued From page 5 W 156 W156 Continued The findings include: (1) OMEP will file verification The facility's unusual incident reports were of notifications with the reviewed on August 29, 2007. An incident dated purchuo incident report and investigation March 2, 2007 indicated that staff observed a bruise on the left leg of Client #1. The client was: summery to provide taken to the emergency room. No further evidence that the state information was documented on the indident report. Interview with the nurse and the Qualified agency was notified and Mental Retardation Professional (QMRP) on the results of the investigation same day revealed that the client was admitted to the hospital with a diagnosis of fracturett leg and were sent in accordance Urinary tract infection (UTI). The QMRP stated to the required regulations and policies: that the incident was investigated and revealed that during a medical appointment on March 1, 2007, Client #1 fell from her wheelchainland sustained a fracture. The three staff involved in the incident was terminated. Further interviews with the QMRP falled to provide evidence that the state agency was notified of the results of the investigation as required by Federal Regulations. (2) Reference response to W156 #(1). q.4.07 2. Review of the Client #3's medical record on onapina August 29, 2007 at approximately 11:00 AM revealed an emergency room report dated April 18, 2007. The ER report indicated a diagnosis of ingestion of a styrofoam cup. Interview with the Qualified Mental Retardation Professional on August 30, 2007 at approximately 11:00 AM revealed that an investigation had been completed. However the results of the investigation was not forwarded to other officials in accordance with State law within five working days of the incident, W 159 483.430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL

PRINTED: 09/17/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY COMPLETED A. BUILDING B. WING 09G121 08/31/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE IDI -WASHINGTON, DC 26619 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROMDER'S PLAN OF DORRECTION COMPLETION DATE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 159 Continued From page 6 W 159 W159 Each client's active treatment program must be integrated, coordinated and monitored by a This Standard will be met qualified mental retardation professional. as evidenced by: This STANDARD is not met as evidented by: Based on observation, interview and repord review the facility failed to ensure that each client's active treatment program was 1) Reference response to W242 and W249. coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: The facility's QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and Informal setting. [See W242] The facility's QMRP failed to ensure that clients (2) Reference response to were provided the opportunities for confinuous active treatment in accordance with their Individual program plans. [See W249] 2. The facility's QMRP failed to review and revise the Individual Program Plan (IPP) once the client 9/10/07. 3) Reference response to WZ57 has successfully completed an objective identified ongoing in the IPP. [See W255] 3. The facility's QMRIP failed to revise objectives aliolot identified in the IPPs that had not been achieved. (4) Reference response to W259. [See W257] philopano 4. The facility's QMRP failed to ensure that a Comprehensive Functional Assessment (CFA)/Individual Support Plan (ISP) had been implemented timely. [See W259] W 242 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN W 242

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIÊR/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	<u> </u>	09G121	B. WING_		08/31/20	107
NAME OF F	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODI 1954 ASTOR PLACE, SE WASHINGTON, DC 20019	i	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CO	(XS) MPLETION DATE
W 242	The individual programmes those clients who lastills essential for particularly for the control of the control	ge 7 cam plan must include, for ck them, training in personal rivacy and independence mited to, toilet training, lental hygiene, self-feeding, rooming, and communication it has been demonstrated velopmentally incapable of	W 242	This Standard will as evidenced by	be met	
	This STANDARD is Based on observation review, the facility for individual program personal skills in both for one of the four control facilities.	s not met as evidented by: on, staff interview and record alled to ensure that clients' plans (IPP) included training in the formal and informal setting fients in the sample. (Client		control will implement to objective to improve personal hygiene in accordance with the	aining her skills on	o lot
	Professional on Aug 11:00 AM revealed of Individual Support P 15, 2007. During the Interdisciplinary Tea approved that the cli improve her persona the IPP revealed no developed or imples program.	on (IDT) recommented and ient receive training to all hygiene skills. Review of evidence that the CIMRP nent a toothbrushing	4	recommendations. recommendations. comper will monitar state monthly basis. Following ISP meet will review and don will review and don	tus on a ing omep where checking further	
W 249	As soon as the inten- formulated a client's		W 249	ensul that training objectives are outling the IPP and implement understance with recommendations.	ented	

₫ 011 **₫ 012**

PRINTED: 09/17/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIÈR/CLIA (XX) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 096121 08/31/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE Washington DC 20019 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) W 249 Continued From page 8 W 249 WZHG interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This Standard will be met This STANDARD is not met as evidenced by: as evidenced by: Based on staff Interviews and record review, the facility failed to ensure that clients were provided: (1) Program objective to wipe her place at the table has been implemented as the opportunities for continuous active treatment in accordance with their individual program plans (IPPs) for two of four clients included in the σηροίημ sample. (Clients #1 and #4) outlined. The findings include: . Client #1 was observed during the breakfast amer will continue to and lunch observations on August 29, 30, and 31, munter chent #1's progress 2007. She ate her meals independently and upon and provide training as completion, the staff took her plate and placemats to the kitchen. Review of Client #1's Individual Program Plan (IPP) objectives on August 30, reded. 2007 revealed a program objective that indicated: the following: "given verbal assistance, (Client (2) Omes well ensure that #1) will wipe her place at the table with 75% program disjective for cheut #1 is implemented accuracy for six consecutive months." The client was not observed to wiping her place at the table: Displing and the staff were not observed to encourage the as outlined thru client to do so. deservation, monetours Interview with the Qualified Mental Retaindation Professional (QMRP) on August 30, 2067 at documentation and 11:00 AM, revealed that the client's programs had been put on hold because the client was placed addutional staff training on bedrest to promote the healing of a sacral decubitus ulcer. Further interview revealed that as needed. the client was receiving her meals in bett. The QMRP also stated that Client #1 had been taken

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		09 G121	B, WING_		08/3	08/31/2007	
NAME OF F	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP C 1954 ASTOR PLACE, SE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) - COMPLETION DATE	
W 249	off bedrest on Auguprograms should have programs should have participated in active accordance with he During observations staff was observed mouth during meals August 16, 2006 rewhich stated, "giver [the client] will wipe napkin with 75% ac There was no evide continuous active trier IPP, 483,440(f)(1)(i) PROCHANGE	ist 20, 2007 and that her ave been implemented. It to ensure that Client #4 extreatment programs in rupp. If from August 29, 31, 2007, feeding and wiping Client #4's in Review of his IPFI dated wealed a program objective in hand over hand assistance, her mouth using a paper coracy for" Indee that Client #1 received eatment in accordance with DGRAM MONITORING &	W 249 W 2 5 5		be met		
	least by the qualifier professional and revolution to limited to situate successfully complete identified in the individual professional (QMRF) the individual prograhad successfully contained in the individual	inot met as evidenced by: ons, staff interviewsland cualified Mental Retardation) failed to review and revise am Plan (IPP) once the client impleted an objective identified the four clients in the		as evidenced by:			
				<u> </u>			

PRINTED: 09/17/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE BURVEY (X1) PROVIDER/SUPPLIER/CLIA OCS MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/31/2007 896121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4954 ASTOR PLACE, SE IDI WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY W255, Continued .. W 255 W 255 Continued From page 10 The facility's QMRP falled to revise Client #3's amer will monitor and track program objectives. chest #3's progress on a On August 29, 2007 at 6:15 PM, Client K3 was observed washing her hands with staff providing comes will update/reuse and/or modify objectives as needed. ungoing hand over hand assistance. Interview with the direct care staff indicated that the clientirequired assistance to perform all of her activities of daily living skills. On August 30, 2007 at approximately 11:00 AM, conver will document status in reveiwing client's IPP dated October 25, 2006, the client had a program objective which stated, in monthly/quarterly puopess notes. "given hand over hand assistance. [the blient] will wash her hands with a disposable cloth/before PM meals on 80% of the trials recorded per month for six consecutive months ...". Record verification of the data sheets on August 30, 2007 indicated that the client achieved the established criteria since June 2006. W 257 W25 W 257 483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE This Standard will be met The individual program plan must be retriewed at a least by the qualified mental retardation as evidenced by. professional and revised as necessary, including, but not limited to situations in which thetclient is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental

Retardation Professional (QMRP) failed to revise: objectives identified in the individual program plans (IPPs) that had not been achieved for two of four clients in the sample. (Clients #2) and #3)

09/25/2007 13:03 FAX 202 518 9685

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES			(X3) DATE SI				RVEY	
TATEMENT AND PLAN OF	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A BUILDING			COMPLE	COMPLETED	
	•	69G121	B. WING	B. WING		OB/3	0B/31/2007	
NAME OF PE	ROVIDER OR SUPPLIER		s	435	et address, city, state, zip col La astor place, se Ashington, dic 20019	DE	•	
(X4) (D PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	7	PROVIDER'S PLAN OF GOR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD RE	(XS) COMPLETION DATE	
₩ 257	on August 30, 200 objectives that indimodel demonstratidiscriminate five an picture representation as measured documentation." If documentation profession action and retardation Profession evested that the othe criteria for the with the QMRP on acknowledged that criteria for the object of been revised. 2. The QMRP faill	ram objectives weretreviewed 7. Client #2 has a pagram cated the following: Isiven ion, [client's name] will ctivities of daily living using tions with 80% accuracy per red by Active Treatment (AT)	W 25	L Q	W257) continued. W257) continued. #3 and #4 productives on a new documentation and implementation of objectives and reveneded, in a time.	lient #2, gram nonthly efounding d minute program se as	1 11,00 12.1	
	progress toward ic reasonable efforts Review of Client # (IPP) dated Octob client will improve skills. Further revian objective which assistance, [the client object for 6 out three consecutive documentation". I Pathologist's quare 2007 through Augiclient required har trials, recorded objective had been	dentified objective after have been made. 3's Individual Program Plan er 25, 2007, revealed that the her functional communication riew revealed that Client #3 had a stated, "given physidal ient) will perform an action with of 10 trials per session for months as measured by AT Review of the Speech terly reviews from Jartuary 27, just 15, 2007 revealed that the inds on assistance on all the There is no evidence that the in revised.						
W 258	483.440(1)(2) PRC	OGRAM MONITORING &	W2	109	· · · · · · · · · · · · · · · · · · ·		,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) PATE SURVEY COMPLETED	
		09G1Z1	B. WING		08/31/2007	
NAME OF P	PROVIDER OR SUPPLIER		. 4	reet address, city, state, zip code 1954 astor place, se 17ashengton, dc 20019	,	
(X4) ID PREFIX TAG	" (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF GORRE (BACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 259	CHANGE At least annually, the assessment of each the interdisciplinary updated as needed. This STANDARD is Based on staff interfacility failed to ensign Functional Assessment (ISP) had been	ne comprehensive functional hiclient must be reviewed by r team for relevancy and	W 259	This Standard will as evidenced by:	be met	
₩ 436	The finding included Interview with the Q Professional (QMR record on August 3 Client #4's annual Immeeting was held of the ISP in the record August 15, 2006. Fronducted to ascerdurent ISP (dated at the QMRP, the program object had not been implessurvey, the facility for Client #4's ISP had as required.	i	W 436	amper has completed an updated the ISP for #4. amper will complete I documents in a time manner, and in accompanion to the standards	ISP ely dance	aliblo7 ongoing
	The facility must fur and teach clients to choices about the u hearing and other o and other devices id	nish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids; braces.	-			

06/24/2018	21:58	FAX			
09/25/2007	13:04	FAX	202	518	9685

IDI

		I AND HUMAN SERVICES		. ,		PRINTED: FORM A OMB NO. (VPPROVED
TATEMENY	OF DEFICIENCIES F CORRECTION	(XY) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MI A. BUII B. WIN	LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G121	-		AND THE REGIONS	<u> </u>	/2007
lame of Pi I D I	ROVIDER OR SUPPLIER		,	4954	FADDRESS, CITY, STATE, ZIF GODE ASTOR PLACE, SE SHENGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	īx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	UŁD BE	(X5) COMPLETION DATE
W 436	Continued From pa	ige 13	W	436	1436 continued		
	Based on observat review, the facility t	is not met as evidenced by: lion, staff interview and record failed to provide burnt boots for ints in the sample. (Client #3)			his Standard will be me wideneed by:	tas	
	The finding includes: Observations during the survey from Attgust 29-30, 2007 revealed that Client #3 was observed					, · ,	
	On August 29, 200 observed wearing PM, the client was her feet. Review odated January 30, pair of "burny boots Additional review on ursing progress in revealed a prescriptional client had a pair of them. Interview will Retardation Profest the client had received.			01	med will follow-up/phoweder to wear bury med will obtain "bury woots/slippers" as	00,3.	9/15/07 ongoing
			,	Q SH O	mRP will provide addition on fund boots/slipper	onal wearing	:

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION OPENTIFICATION NUMBER 09G121		IMBER:	A BUILDING B. WING		·	08/31/2007	
AME OF PRO	OVIDER OR SUPPLIER	-	4954 ASIT	ORIPLACE, TON, DC 28	TATE, ZIP CODE SE 1019	·	
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCE CY MUST BE PRECEDED B LSC IDENTIFYING INFORM	SES YIFUHLL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	(X5) COMPLETI DATE
1 000 1	NITIAL COMME	NTS		1000			
	29, 2007 through was initiated usin process. A rando were selected fro	y was conducted from August 31, 2007. The fundamental submits sample of four resonation of eigness of disabilities.	ne survey sidents				
	observations at t program, intervie dav program, re\	his survey were based he group home, one was at looth the group riew of clinical and ad e the facility's unusua	day home and Inlinistrative		3502.10		
1 052	3502.10 MEAL 5	ERVICE / DINING A	REAS	1 052	1052		-
!	tables, chairs, ea	nall equip dining area ating utensils, and dis at the developmental	shes	,	This Statute w as evidenced be Reference respor Deficiency Repo	<i>l</i>	, in the second
	Based on observeview the GHM	not met as evidenced vation, interview and RP failed to ensure to commended adaptive day program.	repord her		Deficiency Bepo	rt W120	
,	The finding inclu	ides:	1				
	See Federal De	ficiency Report - Cita	tion W120		3504.1		
1 090	3504.1 HOUSE		·	1 090	1090	,	
	maintained in a and eanitary ma	excerior of each GHI safe, clean, orderly, a noner and be free of of dirt, rubbish, and of	attactive,				

NAME OF PROVIDER OR SOLL SELL		STREET ADDR	A BUILDING B. WING ESS, CITY, S' R.PLACE.	TATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 08/31/2007	
IDI			Washingt	DN, DC 20	PROVIDER'S PLAN OF CORRECT	THON (X5)
(X4) ID PREFIX TAG	ノー・ヘリ ログログにんご	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BYIFI LSC IDENTIFYING INFORMATI	ULL ION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO DROSS REFERENCED TO THE APP DEFICIENCY)	ROPRIATE DATE
1090	Based on observa failed to ensure the maintained in a sa sanitary manner. The findings included the environ on August 31, 200. 1. The doors to the had unsightly dark wheel chairs. 2. In resident #1% observed on her deserved on her deserved on the content of the environment of	t met as evidenced by: tion and interview, the e interior of the facility rie, clean, orderly, attita des: mental inspection com or, the following was di marks caused by the s bedroom, a paintingly dresser. The paintingly re frame and was not the st the wall. The House at the painting needed	ducted descrived: sidents residents was was mounted Manager to be	1990	This Statule will be as evidenced by: (1) Door ways have painted. (2) Home Manager replace/ repair (3) Kitchen Itas be cleaned. Home managers che shatus of he daily, addicencerns as	been will frame 9/3/07 cen e eck ome vess
	3. The kitchen carrier touch. 4. The ceitings if	mted on the wall for Cli abinet shelves had am food and were stick proughout the house he	y to		4) Maintenance of Sulomitted for recesary ref	requet pairs.
l 10	paint. 5. The oven had the inside. 3504.15 HOUSE	baked on food and gri KEEPING	ease on	1108	all concerns maintain d	eport ocumentation sues
	Each GHMRP st at least seven (7 to his or her daily	nall assure that each re) changes of clothing a y activities.	sident has ppropriate		addressed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(XZ) MULTI A. BUILDIN	(X3) DATIC SURVEY COMPLETED			
		09G121		B. WING_	100/3/1/2007			
NAME OF P	ROVIDER OR SUPPLIER		4954 ASTO	RBSS, CITY, STATE, ZIP CODE DR PLACE, SE IION, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCE MUST BE PRECEDED BY SC IDENTIFYING INFORMAN	FULL	id Prefix Tag	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPU	E1E	
1 108	Based on observati failed to provide ev	met as evidenced by ion and interview, the idence that each resi t least seven changs	r: • facility ·dent was	108	(5) Oven has been a Home Manager will a to complete routine Inspectations, additionally	leaned continue 2 home ress		
	conducted on Augustnat all of the residence and brassieres) we white clothing was	ommental inspection st 31, 2007, it was (ents undergaments (ere worn and tattered	observed (T-shirts, I The		concerns as they and provide additional staff training as ne	mal eded.		
	conducted on Augu- that none of the residenser drawers. I manager on the sa- residents wear adu- and did not have a interview revealed	ust 31, 2007, it was to sidents had underpaid the network with the hour me day revealed that it protective undergated for underwear, that none of the resident wanted to wear underwear, and the resident in the resident to wear underwear.	bbserved its in their ise It all of the iments Further lents had		Reference response will Federal De Report	p orgo Ficience		
(110	1	EEPING Il ensure that each re good condition, laund		1110	This Statute will met as evidenced by	onaoi		
englika Barra	Based on observatensure each reside	met as evidenced by ion, the GHMRP fails and sciothing was mall clean. Residents #1	d to Intained in	·	Reference response to Federal Deficiency	Report.	,	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-		09G121		B. WING _		08/31/2007
NAME OF I	PROVIDER OR SUPPLIER	• •	STREET AD	DRESS, CITY.	STATE, ZIP CODE	•
ID1				OR PLACE, NON, DC 2	' '	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED BY SCIDENTIFYING INFORM	LUIT	ID PREFIX TAG	PROMDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEPICIENCY)	JLD BE COMPLETE
l 110	Continued From pa	ge 3		1 110	,	
	The finding include	5: :			·	
·	on August 31, 200 the residents under	nental inspection col 7, it was observed th garments (T-shirts, I orn and tattered. Th	lat all of and		1203	
			•		3509.3	
1 203	3509.3 PERSONN	EL POLICIES		1203	3504,3	
•	Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually the relation.			-	This Statute will be as evidenced by:	met
·	This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees.		tiled to	-,	ensure that all outsta	nding ongoing
•	The finding include	s:			for descriptions are	
	Qualified Mental Re records failed to sh job duties were rev	n direct care staff and etardation Profession cow evidence that the lewed with them on a , #3, #4, #5, #6, #7, \$ #14)	bal Staffs Bonual		employer. Human Resource der will continue to rev	our-timent
[20 8	3509,6 PERSONN	EL POLICIES	-	1 206	and discuss job de at the time of him	e.
•	annually thereafter, certification that a l performed and that	ior to employment and shall provide a physically provide a physically inventory has to the employee 's has her to perform the re	sician's been alth status		amer/coordinator will job descriptions made update as no to ensure on going compliance with the standard	1 review conthly eeded

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI	(X3) DATE SURVEY COMPLETED .	٠			
		09G121		B. WING_		08/31/2007			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DORESS, CITY, STATE, ZIP CODE					
IDI			4954 A\$TI WASHING	or Place, Ton, DC 2	0019	-	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED BY SO IDENTIFYING INFORMA	FULL	ID PREFIX TAG	FROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE. COMPLETE	2		
1 206	Based on interview	met as evidenced by and record review, it nsure that all staff ha	he	1206	1206 3509.6 Trus Statute will be me	tasevidenced			
	August 31, 2007 re (Staff #2, #8 and 1: Podiatrist failed to I inventory certifying ability to perform the 3510.5(c) STAFF This Statute is not Based on Interview GHMRP failed to ecardiopulmonary remaintained for each The finding Include Review of the GHM that two of the four of current CPR cer 3519.5 EMERGEN After medical service GHMRP shall prompuardian, his or her no guardian, or the sponsoring agency soon as possible, for	IRP's personnel files wealed three direct of a trace evidence of a trace in their health status at leit job duties. TRAINING met as evidenced by and record review, it is and record review, it is suscitation (CPR) with employee. s: IRP's personell files teen staff files lacked tification. (Staff #7 at	are staff st and esith nd their // he aining on as revealed / evidence ld #12) ed, each nt's ident has atus as altice and	1 226	Personnel files will updated, Health invehous been requested Human Pesources a Admin is tracture As will continue to mand track compliance of health certifications of health certifications. 1226 3510.5 5taff #7 and #12 he been scheduled to the riext CPR certifications. Home Manager/Training will continue to monitor schedule steff as need ensure ongoing complianthis standard.	ssistant ongoing succe sion ates. ave affend angoing ongoing and to	3		
lesite Redu	lation Administration								

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIÈ		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		096121		B. WING_		08/31	/2007	
NAME OF P	ROVIDER OR SUPPLIER	,	STREET ADD	DIRESS, CITY, STATE, ZIP CODE				
1D1			4954 ASTI WASHING	tor place, se Geon, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMS	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
1374	Continued From pa	ge 5		1 274	1374		,	
.'	after the incident.				3519.5		•	
	Based on staff inter GHMRP failed to pr	met as evidenced by view and record revi rovide evidence of th its or guardians of s	iew, the le prompti	••	This Statute will be me evidenced by:	t os		
*1		the four residents in		•	Reference response to	Federal		
-	The finding include	51-	, '	,	Deficiency Report-Cito	ution.	•	
	See Federal Defici	ency Report - Citatiol	h W148		WITE,			
1 379	3519:10 EMERGE	NCIES	i	1 379	1379 3519,10	,		
	each GHMRP shall Health, Health Fact unusual incident or interferes with a resarrangement, well I places the resident be made by telephotollowed up by written.	porting requirements inotify the Department inotify the Department in the Department is possible to the Department in th	int of other bially bare, living way tion shall Ishall be		This Statule will be met evidenced by: Reference response to Federal Deficiency	·	9/7/07 angoing	
	Based on interview failed to ensure the notified of unusual substantially interferand welfare within twork day.	met as evidenced by record review, the Good review, the Good residents of Heal incidents or events the red with each reside twenty-four hours or	HMRP Ith, was bat ht's health		WIS3.		,	
•	The finding include Refer to Federal De	ଃ: ଆସିଥାନ Report W1:	\$ 3			•		
leelth Recu	ation Administration		<u> </u>			 		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIÉR/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT	TIFLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
` .		09G121		.B. WING_		03/31/2007	
NAME OF I	ROVIDER OR SUPPLIER		STREET AD	DIRESS, CITY,	STATE, ZIP CODE		
10)				dr Place Ton, DC 2		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	Œ
1 407	Continued From pa	g <u>e</u> 6		1407			
l 4 07	3520.9 PROFESSI PROVISIONS	ON SERVICES: GEN	VERAL	l 407	1407 3520.9		
•	service provider a v	obtain from each pt written report at least adduring the preced	quarterly				
	This Statute is not Based on staff inter Group Home for Me (GHMRP) Speech I evidence of a writte	met as evidenced by view and record revientally Retarded Pertentiologist failed to per quarterly report on a sample. (Resident to the sample.)	ew, the sons' provide e of the		This Statute will be med our denced by:	cas	
	the client had a spe objective which stated demonstration, [the OFF an item of daily session as measure documentation".	's clinical record revi ech program prograt	m ON and uracy per		amap will follow-up with Speech Pathologist to doto written quarterly report for resident #4.	n the q,14.07 ain ongoing	
I 42 0	training to its reside and maintain those more effectively with environments and to of physical, mental a This Statute is not a Based on staff inter	provide habilitation and provide habilitation and provide habilitation and to enable them the life skills needed to the them the demands of the achieve their optimal and social functioning met as evidenced by the way and record reference that residents we	and cacquire cope eir um levels g. riew, the	i 420	1420 3521 Thus Statute will be met evidenced by:	TOD 9.1.07 ongoing	•

	ENT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121			(22) MULTI A. BUILDIN B. WING	(XS) DATE SURVEY COMPLETED 0/3/31/2907			
NAME OF P	ROVIDER OR SUPPLIER	1 435121	STREET ADD	RESS, CITY, S	STATE, ZIP CODE			
IDI	·.	:	4954 A\$TC WASHING	TOR PLACE, SE IGTON, DC 20019				
(X4) ID PREPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SO IDENTIFYING INFORMS	FULL	ID PREFIX. TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE		
1 420		- tunities for continuou		1420	1420 3521.1, continued			
	Program Plans (IPI included in the same	zance with their Individuals 2s) for one of four resupple. (Resident #1)						
	and lunch observations. She ate her upon completion, the place mats to the k #1's IPP objectives a program objective.	oserved during the bi ions on August 29, 3 meals independently ne staff took her platt itchen. Review of Ri on August 30, 2007 e that indicated the fi	o, and 31, and and and and esident revealed bllowing:		resident #1 have be implemented in account to the IPP.	idance 5 5		
	her place at the tall consecutive month observed wiping he	ance, (Resident#1) le with 75% accurad s." The resident was a place at the table of the place at	y for six not lor were		provide opportunity continue to accordance with individual Program	eatment		
	Professional (QMR 11:00 AM, revealed had been put on he placed on bed rest sacral decubitus ul receiving her meals stated that Resider bedrest on August	Aualified Mental Retains) on August 30, 2016 that the residents poid and the resident value for promote the healifier and that the resident was the DMR in	17 at rograms Vas ng of a lent was also off					
l 422 2	Each GHMRP shall and assistance to resident's Indi	ICN AND TRAINING I provide habilitation, esidents in accordar vidual Habilitation Planet as evidenced by	training Ice with an.	1422 .	This Statule will be as evidenced by:	se met		
selt Regul		and record review, to neuro habilitation, tra		· 4	as concernoed by			

AND PLAN	1D1 4954 A		STREET AL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING DDRESS, CITY, STATE, ZIP CODE FOR PLACE, SE IGTON, DC 28019		COMPL	(X3) DATE SURVEY COMPLETED (98/31/2007	
(X4) ID PREPIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	S (51) (1)	ID PREFIX TAG	PROVIDER'S PLAN OF GO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
I 422	accordance with his (IHP) for two of the: (Residents #1 and # The finding includes	vided to residents in individual Habilitation four residents in the (4) :: observed during the observations on Audito attended to the residents on Audito attended to the residents of the control of th	sample. : gust 29,	1 422				
	took her plate and p Review of Resident: (IPP) objectives on a program objective th "given verbal assists her place at the table consecutive months observed wiping her staff observed to end	lacements to the kitch #1's Individual Progra August 30, 2007 reve eat indicated the folio ance, (Resident #1) No with 75% accuracy " The resident was place at the table re courage the client to	nen. sm Plan ealed a wing: will wipe for six not or Were do so.	·	(1.) amped will conduct staff training. a manager will during mealting further ensure with this star	monitor res to complance rdard.	ongoing	
	Interview with the Qu Professional (QMRP 11:00 AM, revealed that been put on note on bedrest to promot decubitus ulcer and treceiving her meals is stated that the reside bedrest on August 20 programs should hav) on August 30, 200; that the residents property of a set the healing of a set that the resident was not bed. The QMRP enthal been taken to 1, 2007 and that her	7 at pgrams placed acral also		- · · · -			
·	2. The facility failed to carticipated in active accordance with his I During observations to taff was observed fet 4's mouth during metated August 16, 200 lon Administration	treatment programs PP from August 29, 31t, seding and wiping Re cals. Review of his li	in 2007, esident	·	(2) OMRP will completed staff training on of active treatment of active treatment of americal manitoring confermentation of direction and feed to	imprementat t programs, r programi ina provide	16n- '	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED		
· <u>. ' </u>		09G121		B. WING_		08/3	1/2007	
NAME OF P	ROVIDER OR SUPPLIER	;		DDRESS, CITY, STATE, ZIP CODE				
[D]	·			OR PLACE TON, DC 2	20019	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETE DATE	
1422	Continued From pa	ge 9 _		1422	1422, continued	,		
	assistance, Ithe resusting a paper napk There was no evide	ted, "given hand ove identi will wipe her n in with 75% accuracy ence that Rresident # s active treatment in r IPP.	nouth y for"		as needed to further compliance with the	r ensure ùa standard.		
1 423	3521.4 HABILITATI	ON AND TRAINING		[42 3	1423	•		
	resident 's Individu anguing basis to er resident and approp of such Plans wher	monitor and reviews al Habilitation Plan of sure participation of priate GHMRP staff I sever necessary. The il be documented with	in an lithe In revision In schedule		This Statute will be endenced by:	met as	9.6.07 ongoving	
	Based on interview GHMRP failed to e Individual Habilitation	met as evidenced by and record review, t asure each resident! on Pian had been mo resident participated as needed.	he b initored to		Reference response Federal Deficiency W259.	to y Report		
_	The finding include:	s: ·	}				. ,	
	Professional (QMR record on August 3 the resident's annual (ISP) meeting was Review of the ISP is was dated August 1 was conducted to a	Qualified Mental Reta P) and review of Res 0, 2007 at 11:00 AM al Individual Support held on August 15, 2 in the record revealed 15, 2006. Further intersection	lident #4's irevealed, iPlan iD07. If the plan: brview tabout the					
igsith Ramil	to the QMRP, the p new program object	August 15, 2007). A fan had not been wi tives recommended mented. At the time	Hen and Let the ISP			,	, <u>, , , , , , , , , , , , , , , , , , </u>	
STATE FOR			•	draitr l	878M11)f continuation	n sheet 10 of 14	

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	W BRITDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
	09G121		B. WING		08/3	1/2007
NAME OF F	ROVIDER OR SUPPLIER STREET	ADDR	ESS, CITY,	STATE, ZIF CODE		-
IDI			r Place On, DC 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX •TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ALD BE	(X5) COMPLETE DATE
1 423	Continued From page 10	0	423			
	survey, the facility failed to provide evidence that the resident's ISP had been completed and updated as required.	eti			,	
1 424	3521.5(a) HABILITATION AND TRAINING	1	424 ,	1424		,
	Each GHMRP shall make modifications to the resident's program at least every six (6) month or when the client	g		This Statute will be	met	
	 (a) Has successfully completed an objective or objectives identified in the individual Habilitation Plan; 			This Statute will be as evidenced by:	-	
	This Statute is not met as evidenced by: Based on observation, staff interview and recommerciew, the GHMRP falled to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.	1:		Omer will review/revise/objective as needed. Omer will monutor residen progress on a monutally and address concerns	t #3 >	10-2-07 organy
1	The finding includes:			as they arise.	}	
-	The facility's QMRP failed to revise Resident #3' program objectives.	si				
,	On August 29, 2007 at 6:15 PM, Resident #3 was observed washing her hands with staff providing hand over hand assistance. Interview with the direct care staff indicated that the resident requires assistance to perform all of her activities of daily living skills.	,				
	Review of the resident's IPP dated October 25, 2006, the resident had a program objective which stated, "given hand over hand assistance, [the resident] will wash her hands with a disposeble flor Administration	h	·-			

978M11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO.		A BUILDI		(X3) DATE SURVEY COMPLETED	
		89G121		B. WING		08/31/2007	
NAME OF F	PROVIDER OR SUPPLIER	-	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
10!		, , , , ,		CIR PLACE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TRMENT OF DEFICIENCIE / MUST BE PRECEDED BY SCIDENTIFYING (NFORM)	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF GORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE	ETE .
1 424	Continued From pa	ge 11		1 424		,	
	recorded per month". Record verifica	eals on 80% of the train for six consecutives the data sheet esident achieved the since June 2007.	months		-		
l 426	3521.5(c) HABILITA Each GHMRP shall resident's program or when the client:	ATION AND TRAINING I make modifications or at least every six (6	to the	1 426	1426 3521.5(c)		
		ress toward identified sonable efforts have					
	Based on record rev Retardation Profess objectives identified plans (IPPs) that ha	met as evidenced by view, the Qualified Nisional (QMRP) failed in the individual product not been achieved the sample (Client #\$2.5)	ental to revised gram for one		This Statute will be met as evidenced (ii) amer will modify a program objective as	10.20	
1	1. Resident #2's proceeded on August program objectives: Given model demon will discriminate 5 amplicture representation session as measure documentation." Redocumentation and retardation Profession revealed that the clie the criteria for the pawith the QMRP on Alacknowledged that the	ogram objectives were 30, 2007. Client #2 that indicated the following that indicated the following one with 80% accurated by Active Treatment of the Qualified Mental onal (QMRP) document had consistently in ast three quarters. In	has a lowing: name] using cy per nt (AT) entation not met nterview		program objective as omer will minite and programs as well complete observa of program imple and will document in monthly proopers r status of proopa	d track as trons ementation,	

STATEMENT OF AND PLAN OF CA	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION		R/CLIA MBER:	(X2) MUL A BULLD B. WING		(X3) DATE SURVEY COMPLETED			
NAME OF PROM	PER OR SUPPLIER	09G121		08/31/					
IDI .			4954 AST Washing	Address, City, State, ZIP Code STGR PLACE, SE INGTON, DC 28019					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	ter nu	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ALD BIE	(X4) COMPLETE DATE		
Reversiate will non Reverse 15, 2 harm	ech program in the progress town to progress town to progress town to progress town to progress town that the progress of the Speak of the Speak to progress to pr		ailed to e after er 25, e her review ve which esident) out of e on" erly	1 426	1426 3521.5 (c) Objective				
J 432 3521	.7(c) HABILITA	TION AND TRAININ	3	1432	1432 3521.7				
, louis	habilitation and IRP shall include rated to, the follo	training of residents to e, when appropriate, owing areas:	but not	,	This Statute will be as evidenced by:	met			
(c) P shan care)	фосив, рызыл	(including washing, I Ig teeth, and menstru	el						
reviel were	on observation V, the GHMRP (net as evidenced by: n, interview and redor failed to ensure reside ad in hand washing, a	ante						
The fi	nding includes:								
ith Regulation Ad	ministration	4.5							

978M11

STATEMEN AND PLAN	TATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		09G121		B. WING		08/3	1/2007
NAME OF E	Provider or Supplier	-	4954 A\$TQ	R PLACE	STATE, ZIP CODE		
			WASHINGT	ion, de ;	20019	•	
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	ETH I	ID PREFIX TAG	PROVIDERS FLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICHENCY)	ULD BE	(XS) COMPLETE DATE
l 432	Continued From pa	ge 13	. 1	1432	1432, continued	,	
	Professional on Aug 11:00 AM revealed Individual Support F 15, 2007. During th Interdisciplinary Tea approved that the re Improve her person the IPP revealed no developed or impler program.	am (IDT) recommend esident receive training al hygiene skills. Rev evidence that the (M mented a toothbrusibil	oximately had and August ed and ig to view of		amer will ensure that toothbrushing object has been implement outlined in the IPP. amer will review IPP least monthly to ensure all purposant object have been implementations.	<u> </u>	
1 500	3523.1 RESIDENT:	SRIGHTS		1 500	11500	-	
	that the rights of res protected in accorda	ence director shall en idents are observed a ance with D.C. Law 2- applicable District and	and . -137, this		3523.1		
·	This Statute is not r Based on observation review, the GHMRP protections of each r	net as evidenced by: on, interview and reto faited to ensure the resident rights.	ord		This Statute will be r as evidenced by:	net:	'
.	The finding includes:	:			Releinman money L. C.	النسمة	
	See Federal Deficier W137, W148, W153 W249, W255, W257	ncy Report - Citation , W156, W159, W242 , W259 and W436,	W130, 2,		Reference response to Fa Deficiency Report (W130 W137, W148, W153, N W159, W242, W249,), 1156,	10-z-07 ongoing
•					W257, W259, W436		
,	•					1	!
		•				}	
aalth Regula	tion Administration						

09/25/2007 13:06 FAX 202 518 9685 PRINTED: 09/17/2007 FORM APPROVED

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING OB/31/2007 09G121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4954 ASTOR PLACE, SE 101 WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (%) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) IÒ (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 000 R DOO! INITIAL COMMENTS A ficensure survey was conducted from August 29, 2007 through August 31, 2007. The survey was initiated using the fundamental survey process. A random sample of four resilients were selected from a population of eight females: with various degrees of disabilities. The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports. R125 R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125 The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check This Statute will be met as evidenced by: This Statute is not met as evidenced by: Based on the review of records, the GHMRP Human Resource Director will falled to ensure criminal background checks continue to conduct criminal disclosed the criminal history of any prospective ongoina background checks for all employee or contract worker for the previous prospective employees prior seven (7) years, in all jurisdictions within which the prospective employee or contract worker has to employment. worked or resided within the seven (7) years prior to the check. Human Resource Director will The finding includes: ensure that all documents are filed and available for Review of the personnel files on Augusti31, 2007 revealed the GHMRP failed to provide evidence review. of criminal background checks for two direct care: Health Regulation Administration

MANCY BIOTICAL
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

(XB) DATE

978M11

IDI

09/25/2007 13:06 FAX 202 518 9685

2003

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	A. BUILDING	PLE CONSTRUCTION	ON (X3) LATE SU COMPLET		
1		09G121			The same	Ų QUIO	12001.	
NAME OF P	ROYIDER OR SUPPLIER		4954 ASTO	EET ADDRESS, CITY, STATE, ZIP CODE 54 ASTOR PLACE, SE SHUNGTON, DC 20019				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED OF		FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETE DATE	
R 125	Continued From pa	age 1		R 125	R125			
	staff (Staff #5 and :	#6).			Periodic Audits will be conducted to further compliance with this standard.	ensture.		
		•			Background checks for staff #5 and #6 been filed.	or have	,	
		•	-					
Health Damu	ation Administration					-		